



CHCS II Nurse Student Guide

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
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Lesson 1: Navigation

CHCS II is modeled on the design of Microsoft Outlook, with a Folder List, Workspace, File Menu and an Action Bar. This design provides users with multiple navigation options for accessing system features and functionality. Many of the icons or buttons common to a Windows-based application are also used by CHCS II. For example, the icons in the top right hand corner of the screen are Minimize, Maximize, and Close. The  and  buttons in the Folder List are used to expand and collapse folders. Note that when a topic is selected in the Folder List, the folder is highlighted.

Lesson Goal:

The goal of this lesson is to enable you to access and navigate within the CHCS II application.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- Log onto the CHCS II application
- Access modules quickly using Folder List
- Open and close an application module
- Exit the CHCS II application
- Lock CHCS II session

Exercises – CHCS II Training System

Open the CHCS II Training System and complete the exercises below.

Scenario 1

Practice CHCS II navigation using the CHCS II Training System by following these steps:

1. Double-click the CHCS II Training System icon on the computer desktop. A Role Identification screen will appear; the medical radial button is selected by default.
2. Click **OK**.
3. Press the escape key (Esc) on your keyboard twice to progress through the informational messages.
4. Verify the Appointments module is open.
5. The list of current appointments will display.
6. Review the icons in the Action Bar for Appointments. Icons in the Action Bar are relevant to the module that is open. Icons that are used in one module might not be used in another, so what appears in the Action Bar changes.
7. Click the **Telephone Consults** folder in the Folders List to open the Telephone Consults module. The Telephone Consults will display.
8. Click the **Close** icon on the Action Bar to close the Telephone Consults module.
9. To lock the CHCS II application, follow the Menu Path **File > Lock**.

10. The screen will minimize.
11. To reopen the application click the application located on the desktop tool bar area.
12. Click OK.

Note: The CHCS II application restores to previously used screen.

13. Click the Close **X** button on the upper right corner of the Title Bar to end CHCS II. A confirmation message will display.
14. Click **Yes** to confirm the exit.

Lesson 2: Patient Search and Appointments

The Search module enables you to locate and select a patient chart for use in CHCS II. This is synonymous with pulling a paper chart. After you open a patient chart, you have access to the range of patient-specific modules and functions.

The Appointments module is used to view, manage, and open patient appointments. This module displays appointments created in both CHCS and CHCS II. Scheduled appointments, including same-day scheduled appointments, are still created in CHCS. CHCS II pulls scheduled appointments from CHCS on a nightly basis.

Lesson Goal:

The goal of this lesson is to enable you to locate a patient record in CHCS II and use the appointment functions.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- Search for a patient record
- Set search selections for the appointments modules
- Change and save the column order
- Create a walk-in appointment
- Transfer an appointment to a provider
- Add a Nurse to an appointment
- Clear patient

Exercises – CHCS II Training System

Open the CHCS II Training System and complete the exercises below.

Scenario 1

1. Click **Search** in the Folders List to search for a patient. The Patient Search window will display
2. Click in the Last Name field and type **ALEXANDER**, then click **Find** for a list of names. Click on **ALEXANDER, EDWARD P** in the list of names and click **OK**. Edward Alexander's information will appear on the Patient ID line and the Appointments List will display.

You want to set your properties for the Appointments module to display **patient visits for this clinic**, and **visits for the current date appointments**. You also wish to change the column order so that the **Type of visit** column is between the **Patient** and **Status** columns.

3. Click the **Change Selections...** button in the top left corner of the **Appointments** module.
 - a. In the *Clinic* section, click the radio button for **This Clinic**.
 - b. In the *Provider* section, select the radio button **Me**.
 - c. In the *Dates* section, select the correct radio button to show **Today's Only**

appointments.

- d. Click the **Set Selections as Default** button to save your changes.
4. To move a column:
 - e. Scroll to the right just until the **Type** column is visible.
 - f. Click the **Type** column heading and hold down the left mouse button.
 - g. Drag the **Type** column horizontally right (or left).

Release the left mouse button when the **Type** column is between the **Patient** and **Status** columns. Practice moving columns until the *Appointments* screen is most useful for you.

If you wish to save the new column arrangement, click the **Change Selections** button. Then click the **Set Column Order as Defaults**.

You need to Create a New Unscheduled Appointment for **Edward Alexander (a5743)**.

5. Click **New Appt.** on the Action Bar. A New Appointment confirmation window will display.
6. Click **Yes** to complete the New Appointment information for Edward Alexander.
7. Click on **ACUTE APPT (ACUT\$) 30** to select the acute appointment type.
8. Type *Rt. ankle pain* in the Reason for Appointment field and click **OK** to complete the new appointment process for Edward Alexander (The Allergy synchronization simulation from CHCS will begin).

Edward's Alexander's appointment will now appear at the bottom of the Appointment list with a status of **CheckedIn**.

Scenario 2

Col. Violet Alexander's (a5743) Provider had an emergency, so it is necessary to transfer her appointment to a different Provider. Use the **Transfer** icon on the Action Bar to transfer the appointment.

1. In the appointment list, select to highlight Col. Alexander's appointment.
2. Click the **Transfer** icon on the Action Bar.
3. Select **DOCTOR, DAVID** from the dropdown list.
4. Click the **Refresh** icon on the Action Bar to refresh your screen.
5. Click **OK**. Notice that Col. Alexander's name disappears from your appointment list.

Scenario 3

You will be assisting provider User, Test with the Diabetes follow-up appointment for **LCDR Eduardo Suarez (s3217)**.

1. Highlight LCDR Suarez's name on the appointment list.
2. Check-in LCDR Suarez by clicking the **Check-In** icon on the Action Bar.
3. Click the **Add Providers** icon on the Action Bar to open the *Providers and Roles* window.

4. Click the ellipsis (...) button next to Additional Providers #1 to perform a Clinician search for Nurse, Karen.
5. The Clinician search window will display. Enter **NURSE** in the **Last Name** field and click the **Find** button.

Note: In the live CHCS II system a list of Nurses will appear.

6. Select **Nurse, Karen** if the name is not already highlighted.
7. Click the **Select** button to complete the process of adding Nurse Karen as the additional provider for LCDR Suarez. The Clinician search window disappears.
8. The Providers and Roles window re-opens. Notice that Nurse, Karen is now added to the Additional Provider # 1 field.
9. Click the **Role** dropdown button to display the list of role options. Select **Nurse**.
10. Click **OK** to close the *Providers and Roles* window.

Note: The names of additional Providers for a visit are not shown on screens, but the Providers receive credit for the visit.

Scenario 4

To Clear the patient from the Patient ID line.

1. Click **Go** on the Menu Bar to display the dropdown menu.
2. Select **Patient >** to display the sub-menu.
3. On the sub-menu, click **Clear Patient**.

Notice that the Patient ID displays *No Patient Selected* and the Folder List no longer displays the patient specific information.

Lesson 3: Telephone Consults

The Telephone Consults module enables telephone calls to be recorded and tracked. The Telephone Consult (Telcons) window displays telephone consults for specified clinics, users, dates and statuses. From the Telephone Consults module, Telcons can be created, viewed, transferred to another user, and cancelled. Phone numbers can be edited, notes viewed and an encounter can be opened for that appointment.

Lesson Goal:

The goal of this lesson is to enable you to use the Telcon function in CHCS II.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- Set default search and display options
- Open and document a Telcon
- View clerk notes for an appointment
- Edit a call back phone number

Exercises – CHCS II Training System

Open the CHCS II Training System and complete the exercises.

Scenario 1

To set Telcon display properties:

1. Click **Telephone Consults** from the Folder List. The Telephone Consults module opens.
2. Click the **Urgency** column and drag it to the left of the Status column.
3. Click **Change Selections**. The Telephone Consults Search Selections window opens.
4. In the Clinics area, select **This Clinic**.
5. In Provider area, select **Me**.
6. In Dates area, select the **All Outstanding** checkbox.
7. Click **Set Selections as Default**.

Scenario 2

Anna Wunderlich (w8118) phones the clinic to report that she has lost her Zyrtec allergy medication. You review the appointment note and return her call. You speak to her, but need to phone her back after consulting the Provider. She indicates that she is leaving her office and wants her call returned at a different number: 555-9999. You confer with the Provider and complete the Telcon according to the Provider's instructions.

1. Select **Anna Wunderlich's** Telcon appointment.
2. Click **Notes** on the Action bar. The Appointment Comment (Read Only) window opens.
3. Click **Cancel**.
4. Click **Edit Phone #** on the Action bar.
5. Change the Callback Phone Number to (123) 555-9999.
6. Click OK. Notice that the Callback phone number has changed in the type column.
7. Highlight Anna Wunderlich's Telcon appointment and click the **Open** icon to open her appointment. (The Allergy synchronization simulation from CHCS will begin.)
8. The Telcon Quick Entry window displays.
9. In the Provider Note field, enter **NURSE'S NOTE: PHYSICIAN CONSULTED REFERENCE PT LOSING MEDICATION. PT REQUESTS REFILL, ZYRTEC REFILL ENTERED PER PHYSICIANS ORDER.**
10. Select the **Problem List (Chronic)** radio button.
11. Select *ALLERGIC RHINITIS* and click **Add**.
12. Accept the default E&M value of 99371 Lvl I, Simple/Brief.
13. Select the **Save and Open A/P** radio button.
14. Click **OK**. The A/P module opens.
15. Click the **Order Med** tab.
16. In the **New Med Order** field, enter **ZYRTEC** and click **Search**.
17. Select CETIRIZINE (ZYRTEC)--PO 10MG TAB.
18. In the SIG field, enter **1 PO QD PRN #30 RF0** and press **Enter** on your keyboard.
19. A Drug Warning message appears *One Drug Order warning returned*. To override the warning.
20. Click in the **Specify a reason for this override** field. Enter: **PT LOST MEDICATION**.
21. Click the **Accept override** button to submit the order. You are returned to the A/P module.
22. Click **Close** on the Action Bar.
23. You return to the encounter screen.
24. Click **Close** on the Action bar.

Lesson 4: Patient Encounter

The patient encounter consists of the processes indicated.

- Screen the patient
- Perform and record vital signs
- Document patient history and physical exam
- Order Entry in A/P

Lesson Goal:

The goal of this lesson is to document the patient encounter in CHCS II.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- Open the encounter
- Document “reason for visit”
- Verify patient’s allergies
- Document patient’s vital signs
- Document S/O using MEDCIN
- Document A/P
- Disposition and Sign encounter

Screening and Vitals

Once the patient has been checked in, it is now time to open an encounter document for the patient. Appointments with a status of Checked-in, indicates that the patient is ready for screening. The appointment, or encounter for the patient can be opened.

Exercises – CHCS II Training System

Open the CHCS II Training System and complete the exercises below.

Scenario 1

MCPO Susan Cruz (c6453) has come in for a pregnancy test, you create a new appointment. You begin screening along with verifying her allergy information and documenting her vitals.

During this portion of the encounter, you will set the AutoCite properties, screen the patient including entry of the reason for visit and verifying allergies, enter the vital signs and review the results in the electronic SF 600. To get started:

Clinical data:

Field	Data
New Unscheduled Appointment/Telcon Visit	
Appointment Type	Routine Appt (ROUT) 15
Reason for Appointment	Pregnancy Test
	Click OK
To open appt.	Double-click the appointment
Encounter Summary Properties	
	Click the Options button (on the Patient ID line.)
Active Problems	[Accept default]
Allergies	[Accept default]
Active Family	[Select]
Active Medications	[Select]
	Click OK
Screening	
In the Search field	[Enter] Pregnancy Test and click Find Now. Scroll down the list to select: <i>Pregnancy Test</i> Click Add.
For Females Only	
[Birth Control]	[Select] None
G	1
P	1
A	0
LC	1
Last menstrual period	[Two months Prior]
Verify Allergy	[Select] No Known Allergies [Select] Verified This Encounter
	Click Close (Action Bar Icon)
Vitals	
BP	130/70
Rt arm	[Select]
Adult cuff	[Select]

Field	Data
HR	80
Radial	[Select]
Regular	[Select]
RR	16
Temperature F	96.7 F
Oral	[Select]
Ht	[Click] the drop-down list next to Ht [Select] ft/in. [Enter] 5 ft 5 in
Wt	132
Habits	
Tobacco	[Select] No
Alcohol	[Select] No
Pain Severity	
	[Select] 0 Pain Free
Where is pain located?	Note: Add comments when pain scale is selected (other than “0 pain free”)
Verify Allergy	[Select to verify allergies]
	Click Close (Action Bar Icon)
Save Vitals	
	[Select] Save Vitals (Action Bar Icon)
	[Select] Close (Action Bar Icon)

Subjective/Objective

The Subjective portion of the note includes the History of Present Illness (HPI), Past Medical History (PMH) and Review of Systems (ROS). This information comes from the patient and is organized by the provider.

The Objective portion of the note includes the Physical Examination (PE) and is what you observe.

MEDCIN

- Medical terminology engine
- Over 250,000 terms with 5.5 million semantic links
- Linked to ICD-9 and CPT codes in A/P
- Narrative engine used in S/O, A/P, Disposition, Template Management, Screening, and Problems modules
- Allows for rapid data entry

Scenario 2

MCPO Cruz results were positive with a home pregnancy test, and she is now ready to be seen.

To load and unload an S/O template to document an encounter:

1. Click **S/O** on the SF 600. The S/O module opens.
2. Click **Template Mgt** on the Action bar.
3. In the Name Contains field, enter **TRAINING** and click **Find Now**.
4. Select the TRAINING--ECP--PREGNANCY TEST--VISIT template. You can review the template in the Template Preview pane.
5. Click **Load** on the Action bar.
6. Add *the reason for visit is: Pregnancy Test* as a positive finding.
7. Add *nausea* as a positive finding.
8. Click **Find Term** on the Action bar.
9. In the search field, enter **FATIGUE** and click **OK**.
10. Add *feeling tired (fatigue)* as a positive finding.
11. Click the << **Go Back** button to return to the template.
12. Check note in right screen. Identify conflicting statements regarding menstrual period and thought of pregnancy and the need for correction.
13. Click **Plus** sign beside *did not miss the most recent menstrual period* to reverse this statement.
14. Click **Plus** sign beside *she did not think she was pregnant* to reverse this statement.

15. Click the **PMH** tab.
16. Add *reported home pregnancy test* as a positive finding.
17. Add *taking vitamin supplements* as a positive finding.
18. In the Free Text field, enter **CALCIUM 500mg DAILY** and press Enter on your keyboard.
19. Expand *pregnancy history*.
20. Add *age at first pregnancy years old* as a positive finding.
21. In the **Value** field, enter **20** and press Enter on your keyboard.
22. Add *planning to become pregnant* as a negative finding.
23. Click **Find Term** on the Action bar.
24. In the **Search** field, enter **DOWN SYNDROME** and click **OK**.
25. Expand History of Diagnoses, Syndromes And Conditions.
26. Add history of *DOWN'S SYNDROME (TRISOMY-21 MONGOLISM)* as a positive finding.
27. Click the **FamHist** button on the Dashboard.
28. Click the << **Go Back** button to return to the template.
29. Click the **PE** tab.
30. Add *Pain Level (0-10)* as a positive finding.
31. In the **Value** field, enter 0 and press Enter on your keyboard.
32. Click the **Notepad** icon.
33. In the note field, enter **EDUCATION: PT INSTRUCTED TO MAKE OB APPT. PICK-UP PRENATAL VITAMINS FROM PHARMACY. PT INSTRUCTED NOT TO DRINK ALCOHOL OR TAKE OTHER MEDICATIONS** and click **OK**.
34. Click **Close** on the Action bar.

Assessment/Plan

The Assessment and Plan module allows you to document your assessment of a patient's condition and the plan for treatment by entering diagnoses, procedures, patient instructions and order consults, laboratory and radiology procedures and medications.

A/P Processes

- Codes are captured with diagnoses and procedures
- Procedures, orders and other therapies must be associated to a logical diagnosis
- Consults, labs, rads and meds can be submitted or saved to queue

Scenario 3

Continue patient encounter using the CHCS II Training System and complete the exercise below.

1. Click **A/P** on the SF 600. The A/P module opens.
2. In the **Search** field, enter **PREGNANCY TEST** and click **Find Now**.
3. Select **Pregnancy Test V72.9** and click **Add to Encounter**.
4. Click the **Order Lab** tab.
5. In the **New Lab Order** field, enter **HCG** and click **Search**.
6. Select *HCG QL*.
7. Click **Submit**.

Disposition and Signing

- Release of the patient
- Follow-up information
- Items discussed
- E & M code
- Review the note
- Assign a co-signer if required

Scenario 4

Continue patient encounter using the CHCS II Training System and complete the exercise below.

1. Click **Disposition** on the Action bar.
2. Accept the default Disposition, **Released w/o Limitations**.
3. In the Follow Up area, select the **With PCM** checkbox.
4. In the Comments field, enter **CALL TOMORROW FOR PREGNANCY TEST RESULTS**.
5. In the **Meets Output Visit Criteria (Workload)?**, select **Yes** (Default).
6. Accept the default E&M value, 99211 - Established Outpatient Minimal Service.
7. Click **Sign** on the Action bar.
8. Select the **Cosigner Required** checkbox.
9. Click the **Search** button to perform Clinician Search for DOCTOR, DAVID.
10. Select DOCTOR, DAVID.
11. Click **Sign**.

Lesson 5: Previous Encounters

The Previous Encounter module displays a list of a patient's completed encounters. You can append a narrative, amend an encounter, create a new template from the completed encounter and “copy forward” the results of a previous encounter to the current encounter easing effort and saving time in documenting follow-up visits.

Lesson Goal:

The goal of this lesson is to enable you to use the Previous Encounters module in CHCS II.

Learning Objectives:

Upon completion of these modules, you will be able to:

- Display a previous patient encounter
- Append a previous patient encounter
- Amend a previous patient encounter

Exercises – CHCS II Training System

Open the CHCS II Training System and complete the exercises below.

Scenario 1

You need to write a note explaining that during this encounter, LCDR Suarez was educated on a low cholesterol diet.

To view a previous encounters:

1. Perform a search for **LCDR Eduardo Suarez (s3217)**.
2. Click **Previous Encounters** on the Folder List.
3. Select the *HYPERLIPIDEMIA* previous encounter. The encounter note populates below.

To append a previous encounter:

1. Highlight the *HYPERLIPIDEMIA* note and click **Append Narrative** on the Action bar. The Encounter Note window opens.
2. In the **Note Category** field, enter **NURSING NOTE**.
3. In the **Note Title** field, enter **PATIENT EDUCATION**.
4. In the note area, enter **PATIENT WAS EDUCATED ON LOW CHOLESTEROL DIET**.
5. Click **Save** and **Sign**.
6. Click **Sign**.

Scenario 2

You need to copy the results of LCDR Suarez's Hemoglobin A1C lab test into the previous encounter.

To amend a previous encounter:

1. Highlight the DIABETES MELLITUS TYPE II - UNCONTROLLED note and click **Amend Encounter** on the Action bar. The SF 600 opens.
2. Click **Lab** on the Folder List.
3. Click **Time**. The Time Search window opens.
4. Select the **All Time Periods** radio button.
5. Click **OK**.
6. Select the *Hemoglobin A1c* report. The report details populate below.
7. Highlight the report by left-clicking and dragging over the text with your mouse.
8. Perform a right-click and select **Copy to Note**.
9. Click **Close** on the Action bar.
10. Click **Close** on the Action bar to return to the Previous Encounters module.
11. Clear Patient from the Patient ID line.

Lesson 6: Medicomp Forms Tools

Medicomp Form Tools is an alternative mode of documentation during an encounter. The Medicomp Form Tool also provides enterprise management capability for forms that emulates Template Management functionality within the S/O portion of the encounter.

Lesson Goal:

The goal of this lesson is to locate and use available Medicomp Forms in CHCS II.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- Search for a Form
- Load Form
- Document the S/O using a Form

Exercises – CHCS II Training System

Open the CHCS II Training System and complete the exercises below.

Scenario 1

Edward Alexander (a5743) has come in with ankle pain. You wish to document the S/O portion of the note using Forms.

1. In the list of appointments in the appointment module, highlight and open the encounter for Edward.
2. Click the **S/O** button.
3. Click the **Template Mgmt** icon on the Action Bar.
4. In the Name Contains field enter **ANKLE PAIN**.
5. The Name Search should provide one AIM Form for Ankle pain.
6. Highlight the form and click **Load** icon on the Action Bar.
7. The AIM Form will load.
8. Verify the right ankle History Tab is selected before documenting the Note.
9. Click the **T** under the Chief Complaint section to indicate right ankle pain.
10. In HPI, select the **T** to indicate *Local Tissue Swelling Right Ankle*.
11. Click the **Free Text** square to the right of the term you just selected. This will open up a dialog box to add free text or insert text to the note.
12. Type in the following: **PATIENT STATES HE WAS PLAYING FOOTBALL WHEN HE TWISTED HIS ANKLE AND FEELS IT IS SPRAINED.**
13. Click **Insert Text**.
14. Click **Close**.

Note: You will notice an arrow with a question mark beside it. When you right mouse click on it the child terms under Local Tissue Swelling Right Ankle will appear.

15. Select the child terms + ***Localized Soft Tissue Swelling Right Ankle Inside***, and + ***Soft Tissue Swelling R Ankle with Black and Blue Discoloration***, to be more specific with your documentation.
16. Next go to **PMH**.
17. Select **T** to indicate previous **Ankle Fracture** under the Previous Diagnosis section.
18. Once you complete documentation of the patient's HPI, PMH click on the **Right Ankle Physical Exam** Tab.
19. Document the Vital Signs reviewed.
20. Select **F** in the In No Acute Distress box.
21. Click the **Free Text** square to the right of the statement.
22. A free text box will appear. In this box type in: **PT. STATES ANKLE VERY PAINFUL TO WALK ON.**
23. Click **Insert Text**.
24. Click **Close**.
25. In the **Examination of the Right Lower Leg** section click **T** for each item in this section.
26. In the **Appearance of the Right Ankle** section select **F** for the first four entries. Leave the others blank.
27. In the **Tenderness of the Right Ankle** section check **F** Medial Palpation without Tenderness
28. In the **Motion of the Right Ankle** section check **F** Right Ankle without Abnormal Motion.
29. In the **Pain of the Right Ankle** section check **F** No Pain Elicited by Motion.
30. In the **Examination of the Right Foot** section check **F** Right Foot Not Swollen and **F** Right Foot Not Tender to Palpation.
31. In the **Test Results** section, under the **Results of Right Ankle X-Ray**, enter ***FRACTURED RIGHT ANKLE*** in Free Text.
32. Select **AutoNeg** from the Dashboard to indicate a "normal" result for the rest of the history.
33. Click **Close** to save and close the S/O Forms note.
34. Close the module.

Lesson 7: S/O Template Management

Editing a visit template is easier than building a new template. CHCS II has numerous templates available to you and each service has selected templates for their users. Once a template has been created, editing is simple.

Lesson Goal:

The goal of this lesson is to locate available S/O templates in CHCS II and edit templates using MEDCIN.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- Search for Visit Template
- Use Template Edit Mode
- Use Find Term
- Use Browse from Here
- Rename and Save the Template

Exercises – CHCS II Training System

Open the CHCS II Training System and complete the exercises below.

Scenario 1

UTI encounters are among your most frequent clinic visit types. You decide to customize a UTI S/O template for your clinic.

1. Create an appointment for **Karen Smith (s0211)**.
 - Appointment Type: **ACUTE APPT (ACUT\$) 30**
 - Reason for Appointment: **Test Patient**
2. Open the encounter.
3. Click **S/O** on the SF 600.
4. Click **Template Mgt** on the Action bar.
5. In the Name Contains field, enter **UTI** and click **FindNow**.
6. Highlight **VISIT--UTI**.
7. Click **Edit** on the Action bar.
8. In the right pane, under Review of Systems, highlight *fever*.

9. Click **ROS/HPI** on the dashboard. The term is flipped into the **HPI**.
10. Click **Find Term** on the Action bar.
11. In the search field, enter **INCOMPLETE EMPTYING OF BLADDER** and click **OK**.
12. Click + to add *incomplete emptying of bladder* to the template.
13. Click **Browse From Here** on the Action bar.
14. Click + to add *urine odor*.
15. Click **Save As** on the Action bar.
16. In the Template Name field, ENTER **VISIT--UTI FEMALE--[YOUR INITIALS]** and click **Save**.
17. Click **Close** on the Action bar. To return to the S/O Template Management module.
18. Click **No** on the warning window.
19. Click **Close** on the Action bar to return to the S/O module.
20. Click **Close** on the Action bar to return to the SF 600.
21. Clear patient

Lesson 8: Encounter Templates and Order Sets

Templates are used to streamline the encounter documentation process. Each Encounter Template contains placeholders for diagnoses, procedures, orders, Notes templates, AutoCited items, and the associated reason for visit. Once an Encounter Template has been selected and loaded into the encounter, the pre-positioned lists are available within S/O and A/P modules. The Template Management module can be accessed while in an encounter after the screening process and before any charting is completed, or by the folder list. The Encounter Templates can be viewed and edited without an open encounter.

Lesson Goal:

The goal of this lesson is to enable you to use Encounter Templates and Order Sets.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- Use an Encounter Template
- Edit an Encounter Template
- Create an Order Set in A/P
- Merge an Order Set with an Encounter Template

Exercises – CHCS II Training System

Open the CHCS II Training System and complete the exercise below.

Scenario 1

Karen Smith (s0211) comes into the clinic because she is experiencing UTI symptoms. The Nurse needs to document the findings and assessment.

1. Create a **New Appointment** for **Karen Smith (s0211)**.
 - Appointment Type: **(ACUT \$) 30**.
 - Reason for Appointment: type **UTI SYMPTOMS**.
2. Click **OK**.
3. Highlight Mrs. Smith's appt. and click **Open Appt.** on the Action Bar.
4. The Encounter note displays. Click **Templates** on the Action bar.
5. Expand the **My Favorites** folder.
6. Select the **TRAINING--ECP--UTI--ENC** template and click **Add**.
7. Click **OK**.

8. Click **S/O** on the SF 600.
9. Add The Chief Complaint is: *UTI symptoms* as a positive finding.
10. Add *pain during urination (dysuria)* as a positive finding.
11. Click the **Duration grid** and then click **2** and **Days**.
12. Add *feelings of urinary urgency* as a positive finding.
13. Add *diarrhea* as a positive finding.
14. Click the **Duration grid** and then click **1** and **Days**.
15. Document *fever* as a negative finding.
16. Document burning sensation during urination as a negative finding.
17. Click the **PMH** tab.
18. Expand *sexually active*.
19. Add *trying to become pregnant* as a positive finding.
20. Add URINARY TRACT INFECTION as a positive finding. Click the **History** button on the Dashboard.
21. Click the **PE** tab.
22. Add *Pain Level (0-10)* as a positive finding.
23. In the Value field, enter **4** and press Enter on your keyboard.
24. In the Free Text field, enter **AS REPORTED BY PATIENT** and press Enter on your keyboard.
25. Click **A/P** on the Action bar.
26. Select urinary symptoms and click **Add to Encounter**.
27. Click the **Order Lab** tab.
28. In the New Lab Order field, enter **URINALYSIS** and click **Search**.
29. Select **URINALYSIS**.
30. Select the **ASAP** radio button.
31. Click **Submit**.

32. Click **Disposition** on the Action bar.
33. In the Follow Up area, click the **In Clinic** drop-down list and select **CHCS II Test Clinic**.
34. Verify the E&M code.
35. Click **Sign** on the Action bar.
36. Select the **Cosigner Required** checkbox.
37. Click the **Search** button to perform Clinician Search for DOCTOR, DAVID.
38. Select DOCTOR, DAVID
39. Click **Sign**.
40. Close all open modules and return to the Appointments module.

Scenario 2

Edit an Encounter Template:

1. Expand Tools on the Folder List and select **Template Management**.
2. The **Search/Browse** displays by default.
3. Click **Search** on the Action bar.
4. In Template Name type **UTI** and click **Search**.
5. Highlight the **TRAINING-- ECP--UTI--ENC** template.
6. Click **View/Edit** on the Action bar. The Template Details tab opens.
7. In the **Diagnoses** area, click **Add**.
8. In the Search Term field, enter **PAIN DURING URINATION** and click **Search**.
9. Select *pain during urination (dysuria) 788.1* and click **Add Items**.
10. Click **Done**.
11. In the **Other Therapies** area, click **Add**.
12. In the Search Term field, enter **FREQUENT ORAL FLUIDS** and click **Search**.
13. Select *Oral Fluids Frequent* and click **Add Items**.

14. Click **Done**.
15. In the Notes Template area, highlight [List] **TRAINING--ECP-- UTI--VISIT** and click **Remove**.
16. Click **Add**.
17. Click **Search** on the Notes Template Lookup.
18. In the Template Name field, enter **VISIT--UTI FEMALE--TEST**.
19. Click **Search** on the Medcin Template Search.
20. Select **VISIT--UTI FEMALE--TEST** and click **Add Items**.
21. Click **Done**.
22. Click **Save As** on the Action bar.
23. In the Template Name field, enter **ECP--UTI--ENC--TEST** and click **Save**.
24. Click **Close** on the Action bar.

Scenario 3

You have just personalized a UTI Encounter Template and you want to complete it by adding a UTI Order Set.

To create an order set:

1. Create an appointment for **Karen Smith (s0211)**.
 - Appointment Type: **ACUTE APPT (ACUTS) 30**
 - Reason for Appointment: **Test Patient**
2. Click **A/P** on the SF 600.
3. Click the **Order Lab** tab.
4. In the **New Lab Order** field, enter **URINALYSIS** and click **Search**.
5. Select *URINALYSIS*.
6. Select the **ASAP** radio button.
7. Click **Save to Queue**.

8. In the **New Lab Order** field, enter **HCG QL** and click **Search**.
9. Select **HCG QL**.
10. Click **Save to Queue**.
11. In the **New Lab Order** field, enter **URINE CULTURE** and click **Search**.
12. Select *URINE CULTURE*.
13. Click **Save to Queue**.
14. Click the **Order Sets** tab.
15. Click **Save As Order Set**. The Save Encounter Template window opens.
16. In the Template Name field, enter **UTI--ORDERS--TEST** and click **Save**.
17. Close the A/P module.
18. Click **Yes** on the A/P Warning window. You are returned to the SF 600.

Scenario 4

To merge an order set with an Encounter Template:

1. Expand Tools on the *Folder List* and select **Template Management**.
2. Click **Search** on the Action bar.
3. In the Template Name field, enter **UTI**.
4. Click **Search**.
5. Press and hold Ctrl on your keyboard and select **UTI--ORDERS-- TEST** and **ECP—UTI ENC--TEST**.
6. Click **Merge** on the Action bar.
7. Click **Save As** on the Action bar.
8. In the Template Name field, enter **ENC--UTI WITH ORDERS** and click **Save**.
9. Click **Cancel** on the Action bar to go back to the Search/Display window.
10. Click **Search** on the Action bar.
11. In the Template Name field, enter **ENC--UTI WITH ORDERS** and click **Search**.
12. Highlight **ENC--UTI WITH ORDERS** Template.
13. Click **View/Edit** on the Action bar to verify both templates merged.

14. Click **Close** on the Action bar twice, to close the template and then the SF 600.

Lesson 9: Health History Folder

The Health History module displays patient historical data from various modules in one window. The window can be customized to show different modules containing the patient's historical information based on user preference.

Lesson Goal:

The goal of this lesson is to allow you to set up and customize the Health History module.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- Setup Health History Folder
- View and modify Problem information
- View and copy Lab results into an encounter
- View and copy Radiology results into an encounter
- View and modify patient Medication information
- View and modify patient Allergy information
- Set and review the properties for the Vital Signs module

Exercises – CHCS II Training System

Open the CHCS II Training System and complete the exercise.

Scenario 1 Health History Set-up

You would like to set-up the Health History modules to display only Problems, Allergies, and Lab. You will need to pull LCDR Eduardo Suarez's record.

1. Click the **Health History** folder in the Folders List.
2. The Health History module displays with default modules selected.

To customize the Health History folder

3. Click the **Options** button on the Patient ID line. The Health History Design Summary screen will display.
4. Uncheck the box next to **Demographics**.
5. Click the **Align** button to view the format.
6. Click the **OK** button to view the results.
7. Click the **Close** icon on the Action Bar to close the module.

Problems

The Problems module displays a patient's problem list, health care maintenance, dental readiness classification, historical procedures, and family history information. The problem list and family history list is populated when an encounter is signed. Dental readiness classification information is populated by the dental module and is read only.

Scenario 2 Problems

CAPT Clayton Williams (w8867) has previously been diagnosed with cancer of the gallbladder. This needs to be added to his Problems List in the Problems module under Health History.

1. Select (highlight) CAPT Williams' name in the list of appointments. The patient's name must show in the ID line.
2. In the Folder List, click the **Problems** module located under Health History.
3. Expand the Problem list to view CAPT William's Acute/Chronic problems.
4. Click **Add** on the Action Bar
5. The Select Diagnosis window appears with Clinic List selected by default.
6. Select the **Search** tab.
7. Type *Gallbladder cancer* in the Find field.
8. Select GALLBLADDER NEOPLASM MALIGNANT 156.0
9. Click **OK**.
10. Click the down arrow next to the Onset Date to display the date calendar.
11. Enter the Onset Date: **06 Dec 2000**.
12. Use the < > to select the December. Click on the year to display up/down arrows to select the year 2000. Click on day 6.
13. In the Status field accept default: **Active**
14. In the chronicity field accept default: **Chronic**
15. In the Source field accept default: Patient.

Laboratory and Rad Results

The Lab and Rad modules are designed to display the results of laboratory tests and radiology test result data. Results are viewed, not ordered, from this module. Lab and Rad results are pulled from CHCS and an alert is triggered when new results are received.

Scenario 3 Laboratory Results

1. Create a **(ROUT) 15** appointment for LCDR Suarez. Reason for visit is to *Review test results*
2. Open the encounter.
3. Click **Lab** in the Folder List.

Review what appears based upon the default settings.

4. Provider User is specifically interested in the results of the *Microalbumin, urine test*.
5. Highlight the Microalbumin, urine lab result. The result details display in the lower section of the screen. Use the **Display Criteria** to select **Ref Range/Units**.
6. Highlight the result details and right-click. Note the two options:
Copy: puts the results onto the clipboard and they can be pasted into another document
Copy to Note: enters the results onto the patient encounter in the S/O portion
7. Select **Copy to Note**.
8. Close the **Lab** module. Notice the Midroablbumin, urine results appear in the S/O portion of the encounter note.

Do not close SF 600.

Caution: The system does not alert you when you have **Copied to Note**; however, results are copied. Selecting **Copy to Note** again results in multiple copies that cannot be deleted.

Scenario 4 Radiology

Add the following Radiology results to LCDR Suarez's Encounter note.

1. In the Folder List, click the **Radiology** icon. The results of three tests appear.
 - a. Point out the visual cue color code for normal/abnormal results.
2. Highlight the Sinus Series Report.
3. Review what appears in the lower section. (Scroll down to view the results of selected test.)
4. Left click and hold on **Report Text**: Drag mouse to bottom of report to highlight. Right-click and copy to note.
 - Point out you can also copy and paste results to the Add Notes section of the encounter.
5. Close the Radiology module
6. Close the encounter.

Meds

The Meds module lists the patient's past and present medications. The list includes all over-the-counter (OTC), outside, and CHCS II-ordered medications. Current medications can be viewed, re-ordered, or modified and new medications can be added and ordered. Only OTC medications can be added without a patient encounter opened. To renew, discontinue or order medications a patient's current encounter must be opened.

Scenario 5 Meds

Set the Scene: **Eduardo Suarez (a3217)** tells you that he has added taking Tums each day to his daily routine as suggested earlier by Dr. David Doctor. Check his medication health history and update it with the new medication.

1. Search for **LCDR Eduardo Suarez (s3217)** to pull his patient record.
2. In the *Folder List* under Health History, click **Meds**. In the Meds module, the **Search Filter** field default is **Outpatient Current**.
3. Review the functions available using the Action Bar icons: **Add**, **Details**, **Discontinue**, **Modify** and **Renew**.
4. Click the drop-down arrow for the **Search Filter** field and review the options. Change the selection to **All**.
5. Select an existing medication and, on the Action Bar, click the **Details** icon.
6. Click **Discontinue** on the Action Bar.
7. An error box appears indicating this action requires an open encounter (for documentation). Click **OK**.
8. The **Search Filter** selection changes back to **Outpatient Current**.
9. Click the **Add** icon to record Motrin.
10. Click the Record OTC/Outside Medication button.
11. Click the **Medications** button to begin searching for **Tums** in the *Healthcare Data Dictionary Search* window.
12. Select **CALCIUM CARBONATE (TUMS)—PO 500MG TAB** and click the **OK** button.
13. Complete all required fields (including the **Sig: 1 TAB DAILY**) and add a comment that med was a suggestion by his doctor.
14. Click the **OK** button. Note the checkmark in the **OTC** column, which indicates this is an over-the-counter medication.
15. Close the Meds module.
16. Close the encounter.
17. Clear Patient

Allergy

The Allergy Module maintains a list of the patient's reactions to specified allergens. This information is pulled from CHCS and synchronized at the time the CHCS II encounter is opened. The information is stored as coded data from the Health Data Dictionary (HDD) and can be modified as needed.

Scenario 6 Allergy

MG Ramona Marcos (m9876) is on the telephone requesting that her CHCS II allergies record be updated. She was stung by a wasp last month and had a reaction to the sting.

1. Search for MG Marcos' patient record and load her name to the patient ID line.
2. Open **Allergy** from the Folder List.
3. Click the **Add** button to display the *New Allergy* section.
4. Click the **Allergen** button and search for **WASP VENOM** in the *Health Care Dictionary Search for Allergens* window.
5. Double-click **WASP VENOM (WASP VENOM)** to add it as an allergen.
6. Click the **Reaction** button and search for **BRONCHOCONSTRICTION** as a reaction.
7. Highlight **BRONCHOCONSTRICTION** in the left column of the *Health Data Dictionary Search for Reactions* window and click the **Add>>** button to move it to the right column.
8. Click the **OK** button to close the window.
9. Enter the following information:

Field	Data
Info Source	Patient
Onset	[four weeks ago]
Entered by	[accept default]

10. Click the **Save** button.

The clinic has had several patients recently report an allergic reaction to wasp venom, so it needs to be added to the drop-down list of common allergens.

11. Click **Options** to open the *Properties* window.
12. Click **Add** to open the *Add Common List Items* window. Search for and select to highlight **WASP VENOM** and click the **Add to Common List** button.
13. Click **Close**.
14. Click **Save**, then **OK** to **Close** the *Properties* window.
15. Click the **Add** button in the Action Bar, and review the **Allergen** drop-down list. Notice that **WASP VENOM (WASP VENOM)** has been added.

Note: In the live CHCS II system, allergens can also be deleted using **Options**.

16. Close the **Allergy** module and return to the **Appointments** module.

Vital Signs Review

The Vital Signs Review module allows past vital signs to be viewed and/or graphed.

Scenario 7 Vital Signs Review

LCDR Suarez' (s3217) comes in for his diabetes follow-up exam. Review and graph his past vitals.

1. Open the **Appointment** module.
2. Click once to highlight LCDR Suarez Diabetes follow-up visit in the appointment list to pull his patient record.
3. Verify that LCDR Suarez is now listed in the Patient ID line.
4. Open the **Vitals Sign Review** module from the Folder List.
5. Click the **Search Type** button to open the *Time Search* screen.
6. Select the **Sliding Time Range** radio button and select **2 months** as the time range.
7. Click **OK**.
8. Click the **Refresh** button to the right of the time period display.
9. Highlight a single line and click the **Graph Vitals** icon on the Action Bar to open the *Graph Vitals* window.
10. Select each of the **Graph Options**, **Chart Types**, and **Vitals Keys** in turn to review their functions.
11. Click **OK** to exit and return to the Review role with LCDR Suarez' vitals.
12. Highlight the **BP** and **HR** columns. Click the **Graph Vitals** button.
13. Click **OK** after review graph.
14. Click **Close** on the Action Bar to close module.

Lesson 10: Readiness

The Readiness module displays information to determine whether the patient is ready for deployment. An encounter must be open to access the Readiness module. Most of the data displayed on the Readiness window is received from other sources. Data edited in the Readiness window does not update data in its original source.

Lesson Goal:

The goal of this lesson is to learn how to work within the Readiness module in CHCS II.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- View the Readiness module
- Edit the Readiness information

Exercises — CHCS II Training System

Open the CHCS II Training System and complete the scenario exercises below.

Scenario 1

Your task is to update the **Readiness** module for LCDR Eduardo Suarez (S3217). After a record review, you discover the patient had a G6PD done **18 SEP 03** with a normal result.

1. Verify LCDR Suarez's name appears in the patient ID line.
2. Click the **Readiness** module in the Folders List.
3. Click the **Edit** icon on the Action Bar.
4. Update the G6PD information in the *Lab Tests* section by clicking the dropdown in the **Date** field and selecting the appropriate date.
5. Select **Normal** in the **Result** field.
6. Click **Save** on the Action Bar.
7. Close the **Readiness** module.

Lesson 11: Questionnaire Setup & Patient Questionnaires

Lesson Goal:

The goal of this lesson is to enable you to set up and administer Patient Questionnaires in CHCS II.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- Create and release a Questionnaire
- Change the status of a Questionnaire
- Interview a patient

Exercises — CHCS II Training System

Open the CHCS II Training System and complete the scenario exercises below.

Scenario 1

The Headache Clinic has just been brought up on CHCS II. When screening patients for the first time, the clinic has a form for patients to complete prior to seeing a Provider. You have been asked to add this form as a Questionnaire in CHCS II.

1. In the *Folder List* under the Tools folder, click the **Questionnaire Setup** icon.
2. On the Action Bar, click the **New** icon to create a new questionnaire.
3. In the Name field, enter: **HEADACHE – INITIAL VISIT**.
4. In the Instructions to Display field, enter these instructions: **PLEASE COMPLETE ALL QUESTIONS**.
5. Click the drop down arrow next to the Level field and select **Clinic**.
6. Click the drop down arrow next to the Owner field and select **CHCS II Test Clinic**.
7. Click the **Add** button.
8. In the **Question Text** field, add each question below, click the **Answer Type** field drop-down arrow to select the answer type, and enter each possible answer in the space provided.

Note: Do not hit **Enter** after last answer selection. Click **Add** for next question. Do not click **Add** after last question/answer.




Question	Answer Type	Possible Answers
Do you have a headache right now?	Yes/No	Yes No
When was the last time you had a headache?	Multiple Choice	Less than 1 month 1-6 months 7-12 months Greater than 1 year
Have the headaches gotten worse or better?	Multiple Choice	Worse Better
Are you taking any medication for the headaches?	Yes/No	Yes No
Does the medication help the headaches?	Yes/No	Yes No
Have you seen a medical provider regarding these headaches within the last year?	Yes/No	Yes No
Does anyone else in your family suffer from headaches?	Yes/No	Yes No
If so, who suffers from headaches?	Multi Select	Mother Father Sibling Grandparent No One
Is there a lot of stress in your normal day?	Yes/No	Yes No

9. Click **Save** icon on the Action Bar.
10. Highlight the Questionnaire just saved and click the **Mark Ready** icon.
11. Close the Questionnaires Setup module.

Patient Questionnaires

Scenario 2

We will now complete the Headache Initial Visit Questionnaire with CAPT Clayton Williams. Answer each question as if you were completing the Questionnaire for CAPT Williams:

1. In the Appointment module highlight CAPT Clayton William's Headache/physical appointment in the Appointment list
2. In the **Health History** folder, select **Patient Questionnaires**.
3. Click the **Interview** icon on the Action Bar to begin the Questionnaire. The questionnaire window will display.
4. To locate the questionnaire:
 - a. Click  to expand Clinic.
 - b. Click  to expand Questionnaires.
 - c. Click  to expand CHCS II Test Clinic.
 - d. Click **Headache Initial Visit** to select it. The Questionnaire will be displayed.
5. Click **Select** to start the Questionnaire.
6. Click the **Options** button and show Properties. In the Questions drop down box, select **Single Question View**.
7. Click **OK**.
8. Answer each question and click **Next Question.**
9. When the last question is displayed, answer the question.
10. The Patient Questionnaire window will be re-displayed showing the questionnaire that has just been completed.
11. Mark Questionnaire as **Done**.
12. Click the **Encounter** button in the Action bar
13. Show how to link Questionnaires to a specific Encounter
14. Close the Patient Questionnaires module
15. Close encounter note.

Appendix A: Immunizations

CHCS II Immunization consists of two modules:

- The Immunization Admin Module is used to administer and manage vaccines, end users, reports, end user groups, and refrigeration temperature logs. The module is also used to document multiple vaccine entries for selected patients. The Immunizations Admin module can be accessed without having a patient's record open.
- The Patient Immunizations Module is used to manage and track patient immunization records and vaccine history. The Immunization module is patient-specific; therefore, a patient's record must be loaded to the desktop to access this module.

Lesson Goal:

The goal of this lesson is to enable you to manage immunization and vaccine information in CHCS II for all patients.

Learning Objectives:

Upon completion of these modules you will be able to:

- Define vaccine groups
- Track vaccines in stock
- Add details to in-stock vaccines
- Maintain groups
- Document patient vaccines




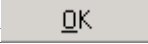
Immunizations Admin





Exercises — CHCS II Training System

Open the CHCS II Training System and complete the scenario exercises below.

Scenario 1

Create a group of immunizations for a battalion that is being deployed:

1. Click the  Immunizations Admin folder in the in the Folder List. The Immunization Admin screen will display with the  tab selected.
2. Click on **User Defined Groups** in the 'Please select the area you wish to Administer' area. The *User Defined Groups* window will display.
3. Click the  button to add a new group. The *Add User Defined Groups* window will open.
4. Type **GROUP A** in the entry area and click . The *User Defined Groups* window will re-display showing the newly defined group.
5. Click to select the name of your end user group in the *User Defined Groups* window and select the following from the *Generic Vaccine Names* list.





- a. Click on **Anthrax** and click 
- b. Click on **Hep A - Hep B** and click 
- c. Click on **Influenza** and click 
- d. Click on **MMR** and click 

The resulting screen will display these in the *Assigned Generic Vaccine Names* window.

You have now successfully added the list of immunizations to your group.

Scenario 2

Next, you need to ensure these vaccines are in stock and have the correct information. To do this, you need to move some available vaccines into stock.

1. In the **Please select the area you wish to administer** field, select **Vaccine Management**.
2. In the **Available Vaccines** box, select each one of the following vaccines, one by one, and click the **Right arrow (>>)** button to move it to the **Vaccines in Stock** box.
 - e. Click on **Anthrax** and click 
 - f. Click on **Hep A - Hep B** and click 
 - g. Click on **Influenza** and click 
 - h. Click on **MMR** and click 
3. Click on the **Mfg/Lot Nbr** button to open the *Vaccines in Stock Information* window.
4. To enter the information in the table below, click in a field and use the drop-down arrow buttons to make selections (For example, click the **Mfg Code** field in the line for **Anthrax**. The *Manufacture List* window opens. Highlight **Ortho Diagnostic Systems, Inc.** and click the **Select** button.).

Note: This data is representational only.

Vaccine	Mfg Code	Lot Nbr	Dosage	Route
Anthrax	Ortho Diagnostics	OD13579	0.25 ml	IM
Hep A – Hep B	Abbott	44444	0.1 ml	IM
Influenza	Baxter	BA 12345	0.1 ml	IM
MMR	Merck	ME67890	0.5 ml	IM

5. Click the **Close** button to close the *Vaccines in Stock Information* window.
6. Close the Immunizations Admin module and return to the *Appointments* screen.

Patient Immunizations

Open the CHCS II Training System and complete the scenario exercises below.

Scenario 1

You are documenting the influenza and anthrax immunizations given to **Col Violet Alexander (a5743)**.

1. Select Col Alexander's patient record and, in the *Folder List*, click the **Immunizations** icon under the Health History folder.
2. Verify that you are on the *Individual Immunizations* tab.
3. Click the **Edit Groups** button.
4. In **User Defined Groups** field, select **GROUP A**.
5. Click the **Right arrow (>)** button to add **GROUP A** to the **Groups Selected** field box.
6. Click the **Close** button.

Note that in the *Immunizations* column, the list of immunizations has been expanded with the immunizations that were defined for Group A and that have been added in stock.

Note that allergy information is available on this tab.

7. Click the **Give Vacc** button to open the *Select Immunization* window.

The four vaccines you put into stock in the Immunizations Administration module are in the list.

8. In the **Immunizations Recommended** box, select **Influenza**.
9. Click the **Right arrow (>)** button to move **Influenza** to the **Immunizations Selected** field.
10. Do the same for the **Anthrax** vaccine.

NOTE: You may find the Group identified immunizations are all pre-selected. In this case, use the **Left arrow (<)** to de-select those you don't want given.

11. Click the **OK** button. The *Vaccine Select* window opens where you can add or change the vaccine information.
12. Click the **OK** button.

The vaccines given are displayed in green in the *Individual Immunizations* box.

13. Do not close the Immunizations module.

Scenario 2

Col Alexander is still in the office and tells you about a recent trip to a nephew's farm. Her civilian doctor recommended she have a tetanus shot **two months ago**, prior to the trip. You want to record this in the medical records while you have the Immunizations module open.

1. Click the *Vaccine History* tab in the Immunizations module.
2. Click the **Add** button to open the *Vaccines* window.
3. Select the **List All Immunizations** check box.
4. Find and select **Tetanus toxoid** in the listing.

5. Click the **Select** button to open the *ADD: ALEXANDER VIOLET Col 20245574320* window.
6. Complete the **Vacc Date** field.
7. Review the other fields and click the **Update** button.
8. On the *Vaccine History* tab, review the record added.
9. Close the Immunizations module and return to the *Appointments* screen.

Scenario 3

Rose Cloud (c0058) is your next patient. You want to review the immunizations that she was given already and those for which she is scheduled.

1. Search for and select Rose Cloud.
2. Open the Immunizations module (Health History folder). The *Individual Immunizations* tab appears with a list of vaccinations.
3. Review the list.
4. Click the *Vaccine History* tab. It appears that she has no record of previous vaccinations.
5. Close the module.